



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Consultants in Pain Medicine

Respondent Name

St Paul Fire & Marine Insurance Co

MFDR Tracking Number

M4 -16-2476-01

Carrier's Austin Representative

Box Number 05

MFDR Date Received

April 18, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted.

Amount in Dispute: \$142.32

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider alleges they are entitled to reimbursement for the services at issue. The Carrier has reviewed the Medicare base rate and calculations utilized and determined that the Maximum Allowable Reimbursement was properly calculated, as the services in dispute are included in the Medicare base rate for CPT code G0431 reimbursed under this rate of service. The Carrier contends the Provider is not entitled to additional reimbursement for the disputed services."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 15, 2015	82570, 81003, G6041, G6056, G6045, G6046	\$142.32	\$142.32

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.210 sets out the documents required to be filed with medical bills during the medical billing process.
- 28 TAC §134.203 sets out the reimbursement guidelines for professional services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P12 – Workers compensation jurisdictional fee schedule adjustment

- 251 – The attachment/other documentation that was received was incomplete or deficient
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

Issues

1. Did the requestor meet division documentation requirements?
2. Were Medicare policies met?
3. What is applicable rule pertaining to reimbursement?
4. Is reimbursement due?

Findings

1. The insurance carrier denied the disputed services as 251 – “The attachment/other documentation that was received was incomplete or deficient.” 28 TAC §133.210 does not require documentation to be submitted with the medical bill for the services in dispute however, a signed physician’s order was found within the submitted documentation. The carrier’s position is not supported.
2. 28 Texas Administrative Code §134.203 (b) requires that For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
 - (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

The requestor seeks reimbursement for CPT Code 82570 defined by the AMA CPT Code book as “Creatinine; other source.” The CMS 2015, National Correct Coding Initiative Policy Manual, Chapter 10, Page X-7, Section E. titled , “Drug Testing” <https://www.cms.gov> states, “Providers performing validity testing on urine specimens utilized for drug testing should not separately bill the validity testing. For example, if a laboratory performs a urinary pH, specific gravity, creatinine, nitrates, oxidants, or other tests to confirm that a urine specimen is not adulterated, this testing is not separately billed.” No additional payment can be recommended. No other CCI edits or Medically Unlikely Edits were found. The remaining services in dispute will be calculated per division rules and fee guidelines.

3. 28 TAC §134.203(a) states that “‘Medicare payment policies’ when used in this section, shall mean reimbursement methodologies, models, values and weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.” The services in dispute are clinical laboratory services; therefore, Medicare policies for the clinical laboratory services must be met. The services in dispute are addressed in the CMS Clinical Laboratory Fee Schedule. The requestor billed the following AMA CPT codes/descriptions as follows:
 - CPT Code – 81003 – Urinalysis auto w/o scope
 - CPT Code – G6041 – Assay of urine alkaloids
 - CPT Code – G6045 – Assay of dihydrocodeinone
 - CPT Code – G6046 – Assay of dihydromorphinone
 - CPT Code – G6056 – Assay of opiates

Review of the medical bill finds that current AMA CPT Codes were billed. The requestor met 28 TAC §134.203(b). The remaining services in dispute will be reviewed per applicable rules and fee guidelines.

4. 28 Texas Administrative Code §134.203 (e) states:

The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows:

- (1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and,
- (2) 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service.

CMS payment policy files identify those clinical laboratory codes which contain a professional component, and those which are considered technical only. The codes in dispute are not identified by CMS as having a possible professional component, for that reason, the MAR is determined solely pursuant to 28 TAC §134.203(e)(1). The maximum allowable reimbursement (MAR) for the services in dispute is 125% of the fee listed for the codes in the 2015 Clinical Diagnostic Laboratory Fee Schedule found on the Centers for Medicare and Medicaid Services website at <http://www.cms.gov>. The total MAR is calculated as follows:

81003 – Allowable \$3.06 x 125% = \$ 3.83
G6041 – Allowable \$40.85 x 125% = \$51.06
G6045 – Allowable \$28.10 x 125% = \$35.13
G6046 – Allowable \$34.98 x 125% = \$43.73
G6056 – Allowable \$26.48 x 125% = \$33.10

The total allowable for the services in dispute is \$166.85.

5. The total recommended payment for the services in dispute is \$166.85. The requestor is seeking \$142.32. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$142.32.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$142.32 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	May 12, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.